LAWRENCE & MEMORIAL HOSPITAL

July 27, 2004

Cristine Vogel, Commissioner
State of Connecticut
Office of Health Care Access
410 Capitol Ave.
MS #13HCA
P.O. Box 340308
Hartford, CT 06134-0308

Dear Commissioner Vogel:

Enclosed is a Letter of Intent to discontinue Lawrence & Memorial Hospital's Outpatient OB/GYN Clinic. The private practice OB/GYN physicians in the community are anxious to take over the care of this patient population as soon as possible. They believe the increase in volume in their private practices will assist them in covering their overhead expenses and make their practices more financially viable. Given the volatility of the OB specialty due to the medical malpractice premium crisis, we are requesting an expedited review of this request.

Please let me know if you need further information in order to process our request.

Sincerely,

Cynthia B. Kane
Executive Vice President and
Chief Operating Officer

State of Connecticut
Office of Health Care Access
Letter of Intent/Waiver Form
Form 2030

All Applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-643-79 of OHCA's Regulations. Please submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If there are more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	Lawrence & Memorial Hospital	
Doing Business As	N/A	
Name of Parent Corporation	Lawrence & Memorial Corporation	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	365 Montauk Avenue New London, CT 06320	
Applicant type (e.g., profit/non-profit)	Non-profit	
Contact person, including title or position	Cynthia B. Kane Executive Vice President & Chief Operating Officer	
Contact person's street mailing address	365 Montauk Avenue New London, CT 06320	
Contact person's phone #, fax # and e-mail address	(860) 442-0711 ext. 2071 FAX (860) 444-3741 CKane@LMHosp.Chime.Org	

SECTION II. GENERAL APPLICATION INFORMATION

a. Proposal/Project Title:

Discontinue Outpatient OB/GYN Clinic

b. Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.:

☐ New (F, **S**, Fnc) ☐ Replacement ☐ Additional (F, S, Fnc)

☐ Expansion (F, S, Fnc) ☐ Relocation ☒ Service Termination

☐ Bed Addition` ☐ Bed Reduction ☐ Change in Ownership/Control

☐ Capital Expenditure/Cost, pursuant to Section 19a-639, C.G.S.:

☐ Project expenditure/cost cost greater than $ 1,000,000

☐ Equipment Acquisition greater than $ 400,000

☐ New ☐ Replacement ☐ Major Medical

☐ Imaging ☐ Linear Accelerator

☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

c. Location of proposal (Town including street address):

365 Montauk Avenue, New London, CT 06320

d. List all the municipalities this project is intended to serve:

_____

e. Estimated starting date for the project: October 1, 2004

f. Type of project: 25 **(Fill in the appropriate number(s) from page 7 of this form)**

Number of Beds (to be completed if changes are proposed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
N/A				

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

a. Estimated Total Capital Expenditure: $ 0

b. Please provide the following breakdown as appropriate:

Construction/Renovations	$
Medical Equipment (Purchase)	
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)	
Sales Tax	
Delivery & Installation	
Total Capital Expenditure	**$**
Fair Market Value of Leased Equipment	
Total Capital Cost	**$** 0

Major Medical and/or Imaging equipment acquisition:

Equipment Type	Name	Model	Number of Units	Cost per unit
None				

Note: Provide a copy of the contract with the vendor for major medical/imaging equipment.

c. Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan

☐ Charitable Contributions ☐ CHEFA Financing ☐ Grant Funding

☐ Funded Depreciation ☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following (if applicable):

1. Currently what types of services are being provided? If applicable, provide a copy of each Department of Public Health license held by the Petitioner.
2. What types of services are being proposed and what DPH licensure categories will be sought, if applicable?
3. Who is the current population served and who is the target population to be served?
4. Identify any unmet need and how this project will fulfill that need.
5. Are there any similar existing service providers in the proposed geographic area?
6. What is the effect of this project on the health care delivery system in the State of Connecticut?
7. Who will be responsible for providing the service?
8. Who are the payers of this service?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER OF CON FOR REPLACEMENT EQUIPMENT

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment.

- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____.
- ☐ The cost of the equipment is not to exceed $2,000,000.
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit for Section V only.

AFFIDAVIT

Applicant: Lawrence & Memorial Hospital

Project Title: Discontinue Outpatient OB/GYN Services

I, William T. Christopher, President/CEO of
(Name) (Position – CEO or CFO)

Lawrence & Memorial Hospital being duly sworn, depose and state that the information provided in this CON Letter of Intent/Waiver Form (2030) is true and accurate to the best of my knowledge, and that Lawrence & Memorial Hospital complies with the
(Facility Name)

appropriate and applicable criteria as set forth in the Sections 19a-630, 19a-637, 19a-638, 19a-639, 19a-486 and/or 4-181 of the Connecticut General Statutes.

Signature: William T. Christopher 7/28/04
Date

Subscribed and sworn to before me on 7/28/04

Notary Public/~~Commissioner of Superior~~ Court

My commission expires: 6/30/08

JACQUELINE E. COOPER
NOTARY PUBLIC
MY COMMISSION EXPIRES JUNE 30, 2008

Project Type Listing

Please indicate the number or numbers of types of projects that apply to your request on the line provided on the Letter of Intent Form (Section II, page 2).

Inpatient

1. Cardiac Services
2. Hospice
3. Maternity
4. Med/ Surg.
5. Pediatrics
6. Rehabilitation Services
7. Transplantation Programs
8. Trauma Centers
9. Behavioral Health (Psychiatric and Substance Abuse Services)
10. Other Inpatient

Outpatient

11. Ambulatory Surgery Center
12. Birthing Centers
13. Oncology Services
14. Outpatient Rehabilitation Services
15. Paramedics Services
16. Primary Care Clinics
17. Urgent Care Units
18. Behavioral Health (Psychiatric and Substance Amuse Services)
19. MRI
20. CT Scanner
21. PET Scanner
22. Other Imaging Services
23. Lithotripsy
24. Mobile Services
25. Other Outpatient
26. Central Services Facility

Non-Clinical

27. Facility Development
28. Non-Medical Equipment
29. Land and Building Acquisitions
30. Organizational Structure (Mergers, Acquisitions, Affiliations, and Changes in Ownership)
31. Renovations
32. Other Non-Clinical

SECTION IV. PROJECT DESCRIPTION

This proposal is a request for authorization, effective October 1, 2004, to discontinue Lawrence & Memorial's outpatient Ob-Gyn Clinic, which evolved since the 1960's as a collaborative program between Lawrence & Memorial Hospital and private practice obstetricians to provide obstetrical services to indigent patients. The Ob-Gyn Clinic was organized at Lawrence & Memorial's main campus, 365 Montauk Avenue, New London, CT, and over the decades employed various organizational models for physician services incorporating volunteer and obligatory service coverage until the early 1990's. At that time, private practice physicians no longer wanted to co-operate with an obligatory coverage arrangement and Lawrence & Memorial employed physicians to cover the Clinic. Services were expanded to include Gyn, and gradually non-indigent patients were accepted. During the last decade the organizational model evolved to incorporate one physician employed to cover the Clinic half time, supplemented by one private practice group contracted to cover half time. In mid-2003, services of the employed physician were discontinued and the private practice group contracted to cover half time was retained for full-time services, on an interim basis, to allow time for a re-evaluation of the service delivery model. An Ob-Gyn Clinic Task Force including management, staff, physicians and Board representation was commissioned. The goal of the task force was "to review and recommend alternatives to the current model for the Ob-Gyn Clinic that reduces the level of financial support by Lawrence & Memorial Hospital and integrates the services with other community based providers to ensure the long-term health of the Hospital and the private practices in the community." The Task Force considered five organizational models. Following a detailed review of the options, the Task Force determined that the best-balanced model would be to transition the patient population to one of several OB/GYN practices in the local community. Lawrence & Memorial Hospital would continue to be involved by providing the ancillary social work and nutrition support to patients identified as high risk.

Lawrence & Memorial Hospital has eleven private practice Ob-Gyn physicians on staff and they maintain private practice office locations primarily in New London and Groton. Most private practice Ob-Gyn physicians have asked to have patients referred to them for care to increase their patient volumes, thereby helping to offset expenses associated with medical malpractice insurance premiums. Without this additional volume, their practices are at risk and it threatens their ability to continue to provide obstetrical services within the service area.

Preliminary implementation plans include continuance of current provider relationships for present obstetrical patients, information and referral services for current GYN patients, physician referral services and public advertising and informational communications, provision of translation services, and continuation of High-Risk OB Team conferences.

To assure that high quality care is maintained, Lawrence & Memorial Hospital and participating Ob-Gyn physicians have committed to collecting information on access, clinical quality, and patient satisfaction. This information will be reviewed and discussed quarterly at departmental meetings.

During the most recent three fiscal years the population served averaged 1164 patients, more than 90% from Lawrence & Memorial's primary service area, including approximately 73% from the towns of New London, Groton and Waterford. The average patient age is 30 and approximately 20% are under 20 years of age. The payer mix includes 58% Medicaid/Medicare, 28% private insurance and 14% self pay. Annual Clinic volume is approximately 5700 encounters including 74% obstetrical and 26% gynecological. Annually, the Clinic averages 300 deliveries that represent 17% of the total deliveries at Lawrence & Memorial Hospital.

The Hospital has developed a detailed transition plan and communication plan to ensure that women in our community receive appropriate care and are not faced with barriers to access. We believe this model could lead to a better "safety net" for these patients and better long-term care. In addition, we believe this proposal will assist our local obstetricians in staying in practice in our community.

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 4, 2004

Cynthia Kane
Executive Vice President, Chief Operating Officer
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

Re: Letter of Intent, Docket Number 04-30348
Lawrence & Memorial Hospital
Proposal to Discontinue Outpatient Ob-Gyn Clinic
Notice of Letter of Intent

Dear Ms. Kane:

On July 30, 2004, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of Lawrence & Memorial Hospital ("Applicant") for the Proposal to Discontinue Outpatient Ob-Gyn Clinic, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Day* pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

SCE:LKG:bko

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 4, 2004

Purchase Order # HCA05-037
Fax: (860) 442-5443

The Day Publishing Company
47 Eugene O'Neill Drive
Box 1231
New London, CT 06360

Gentlemen/Ladies:

Please make an insertion of the attached copy, in a single column space, set solid under legal notices, in the issue of your newspaper by no later than Friday, August 6, 2004.

Please fax evidence that the legal notice was published by the date requested above to (860) 418-7053. In addition, please send the original legal notice (full tear sheet is required) with the invoice.

If there are any questions regarding this legal notice, please contact Laurie Greci at (860) 418-7001.

KINDLY RENDER BILL IN DUPLICATE ATTACHED TO THE TEAR SHEET.

Sincerely,

Susan Cole England

Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:LKG:bko

c: Kathy Howe, OHCA

PLEASE INSERT THE FOLLOWING:

Pursuant to Section 19a-638 of the Connecticut General Statutes as amended by Section 1 of Public Act 03-17, the Office of Health Care Access ("OHCA") has received a Letter of Intent to file the following Certificate of Need application:

Applicant:	Lawrence and Memorial Hospital
Town:	New London
Docket Number:	04-30348
Proposal:	Proposal to Discontinue Outpatient Ob-Gyn Clinic.
Total Capital Expenditure:	$0

The Applicant may file its Certificate of Need application between September 28, 2004 and November 27, 2004. Interested persons are invited to submit written comments to OHCA regarding the Letter of Intent or the Certificate of Need application, when it is submitted by the Applicant. Such comments should be directed to:

Cristine A. Vogel
Commissioner
Office of Health Care Access
410 Capitol Avenue, MS#13HCA
P.O. Box 340308
Hartford, CT 06134-0308

The Letter of Intent is available for inspection at OHCA. A copy of the Letter of Intent may be obtained from OHCA at the standard copy charge. The Certificate of Need application will be made available for inspection at OHCA, when it is submitted by the Applicant. A copy of the Certificate of Need application may then be obtained from OHCA at the standard copy charge.

Confirmation Report – Memory Send

Time : Aug-04-2004 14:09
Tel line : 8604187053
Name : OFFICE OF HEALTHCARE

Job number	:	188
Date	:	Aug-04 14:08
To	:	918604425443
Document pages	:	002
Start time	:	Aug-04 14:08
End time	:	Aug-04 14:09
Pages ,sent	:	002
Status	:	OK

Job number : 188 *** SEND SUCCESSFUL ***

STATE OF CONNECTICUT
OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 4, 2004

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Sincerely,

Susan Cole England
Susan Cole England
Certificate of Need Supervisor

Attachment

SCE:LKG:bko

c: Kathy Howe, OHCA

An Equal Opportunity Employer
410 Capitol Avenue, MS #13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308
Telephone: (860) 418-7001 • Toll free (800) 797-9688
Fax: (860) 418-7053

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

August 4, 2004

Cynthia Kane
Executive Vice President, Chief Operating Officer
Lawrence & Memorial Hospital
365 Montauk Avenue
New London, CT 06320

RE: Certificate of Need Application Forms, Docket Number 04-30348-CON
Lawrence & Memorial Hospital
Proposal to discontinue L & M Outpatient Ob-Gyn Clinic

Dear Ms. Kane:

Enclosed are the application forms for Lawrence & Memorial Hospital's Certificate of Need ("CON") proposal for the Proposal to discontinue L & M Outpatient Ob-Gyn Clinic with no associated capital expenditure.

According to the parameters stated in Section 19a-638 of the Connecticut General Statutes as amended by Public Act 03-17, the CON application may be filed between September 28, 2004, and November 27, 2004. The analyst assigned to the CON application is Laurie Greci. Please feel free to contact him/her at (860) 418-7001, if you have any questions.

Sincerely,

Susan Cole

Susan Cole
Certificate of Need Supervisor

Enclosure

State of Connecticut
Office of Health Care Access
Certificate of Need Application

Please complete all questions. If any question is not relevant to your project, Not Applicable will be an acceptable response. Your Certificate of Need application will be eligible for submission no earlier than September 28, 2004, and may be submitted no later than November 27, 2004. The Analyst assigned to your application is Laurie Greci and may be reached at the Office of Health Care Access at (860) 418-7001.

Docket Number: 04-30348-CON

Applicant(s) Name: Lawrence & Memorial Hospital

Contact Person: Cynthia Kane
Contact Title: Executive Vice President, Chief Operating Officer
Lawrence & Memorial Hospital
Contact Address: 365 Montauk Avenue
New London, CT 06320

Project Location: New London

Project Name: Proposal to Discontinue Outpatient Ob-Gyn Clinic

Type proposal: Section 19a-638, Connecticut General Statutes

Est. Capital Expenditure: $ 0

1. Expansion of Existing or New Service

What services are currently offered at your facility that the proposal will augment, replace, or terminate? Please list.

2. State Health Plan

No questions at this time.

3. Applicant's Long Range Plan

Is this application consistent with your long-range plan?

☐ Yes ☐ No

If "No" is checked, please provide an explanation.

4. Clear Public Need

A. Explain how it was determined there was a need for the proposal in your service area.

i) Provide the following information:
   a) Primary and secondary service area towns
   b) If existing facility/service, the unit of service (i.e. procedure, scan, visit, etc.) for the past three fiscal years by service area town
   c) If new facility/service, the population to be served, including the number of individuals to receive the proposed service(s). Include demographic Information, as appropriate.
   d) Scheduling backlogs in service area
   e) Travel distance from proposed site to service area towns
   f) Hours of operation of existing/proposed service

ii) Identify the existing providers of the proposed service in your service area. What will be the effect of your proposal on existing providers (i.e. patient volume, financial stability, quality of care, etc.)?

iii) Provide the units of service projected for the first three years of operation of the proposed service. **Include the derivation/calculation.**

B. Will your proposal remedy any of the following barriers to access? Please provide an explanation.

☐ Cultural ☐ Transportation

☐ Geographic ☐ Economic

☐ None of the above ☐ Other (Identify) _____

If you checked other than None of the above, please provide an explanation.

C. Provide copies of any of the following plans, studies or reports related to your proposal:

☐ Epidemiological studies ☐ Needs assessments

☐ Public information reports ☐ Market share analysis

☐ Other (Identify) _____

5. Quality Measures

A. If the proposal is for a new technology or procedure, have all appropriate agencies approved the proposed procedure (e.g., FDA etc.)?

☐ Yes ☐ No ☐ Not Applicable

If "No", please provide an explanation.

B. Check off all the Standard of Practice Guidelines that will be utilized by the Applicant for the proposed service. Please submit the most recent copy of each report related to the proposal:

☐ American College of Cardiology ☐ National Committee for Quality Assurance ☐ Public Health Code & Federal Corollary

☐ National Association of Child Bearing Centers ☐ American College of Obstetricians & Gynecologists ☐ American College of Surgeons

☐ Report of the Inter-Society Council for Radiation Oncology ☐ American College of Radiology ☐ Substance Abuse and Mental Health Services Administration

☐ Other: Specify _____

C. Provide a brief summary of how the Applicant plans to meet the guidelines related to this proposal.

D. Submit a list of all key professional and administrative personnel, including the Applicant's Chief Executive Officer (CEO) and Chief Financial Officer (CFO), Medical Director, physicians, nurses, therapists, counselors, etc., related to the proposal and a copy of their Curriculum Vitae.

Note: For physicians, please provide a list of hospitals where the physicians have admitting privileges.

E. Provide a copy of the most recent inspection reports and/or certificate for your facility:

☐ DPH ☐ JCAHO

☐ Fire Marshall Report ☐ Other States Health Dept. Reports (new out-of-state providers)

☐ AAAHC ☐ AAAASF

☐ Other: _____

Note: Above referenced acronyms are defined below. [1]

F. Provide a copy of the following (as applicable):

☐ A copy of the related Quality Assurance plan

☐ Protocols for service (new service only)

☐ Patient Selection Criteria/Intake form

6. Improvements to Productivity and Containment of Costs

In the past year has your facility undertaken any of the following activities to improve productivity and contain costs?

☐ Energy conservation ☐ Group purchasing

☐ Reengineering ☐ None of the above

☐ Application of technology (e.g., computer systems, robotics, telecommunication systems, etc.)

☐ Other (identify)_____

[1] DPH – Department of Public Health; JCAHO – Joint Commission on Accreditation of Hospitals Organization; AAAHC – Accreditation Association for Ambulatory Health Care, AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities, Inc.

7. Miscellaneous

A. Will this proposal result in new (or a change to) your teaching or research responsibilities?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

B. Are there any characteristics of your patient/physician mix that makes your proposal unique?

☐ Yes ☐ No

If you checked "Yes," please provide an explanation.

C. Provide the following licensing information:

i) If you are currently licensed, provide a copy of the State of Connecticut Department of Public Health license currently held.

ii) The DPH licensure category you are seeking.

iii) If not applicable, please explain why.

8. Financial Information

A. Type of ownership: (Please check off all that apply)

☐ Corporation (Inc.) ☐ Limited Liability Company (LLC)

☐ Partnership ☐ Professional Corporation (PC)

☐ Joint Venture ☐ Other (Specify): _____

B. Provide the following financial information:

i) Pursuant to Section 19a-644, C.G.S., each hospital licensed by the Department of Public Health is required to file with OHCA copies of the hospital's audited financial statements. If the Applicant is a hospital that has filed its most recently completed fiscal year audited financial statements, the Applicant may reference that filing for this proposal.

ii) If the Applicant has no audited financial statements, please submit an unaudited Balance Sheet and Income Statement or Statement of Operations for the most recently completed fiscal year. These statements should be externally prepared and submitted on the preparer's letterhead.

iii) If the Applicant is a hospital, provide the cash equivalent balance at the date of submission of this application.

iv) If the Applicant is a hospital, provide a copy of the most recently completed internal monthly financial statement.

v) If the Applicant is a hospital, the name and units of service for the new cost center to be established for the proposal.

vi) The name of the entity that will be billing for the proposed service.

9. Major Cost Components/Total Capital Expenditure

Submit a final version of all capital expenditures/costs as follows:

Medical Equipment (Purchase)	$
Imaging Equipment (Purchase)	
Non-Medical Equipment (Purchase)*	
Land/Building (Purchase)	
Construction/Renovation	
Other (Non-Construction) Specify:_____	
Total Capital Expenditure	**$**
Medical Equipment (Lease (FMV))	$
Imaging Equipment (Lease (FMV)	
Non-Medial Equipment (Lease (FMV))*	
Fair Market Value of Space – Capital Lease	
Total Capital Cost	**$**
Capitalized Financing Cost	
Total Capital Expenditure with Cap. Fin. Costs	$

* Provide an itemized list of all non-medical equipment.

10. Type of Financing

A. Check type of funding or financing source and identify the following anticipated requirements and terms: (Check all which apply)

☐ Applicant's equity:
Source and amount:

Operating Funds Source/Entity Name Available Funds	$ _____ _____ _____
Contributions	$ _____
Funded depreciation	$ _____
Other	$ _____

☐ Grant:

Amount of grant	$ _____
Funding institution/ entity	_____

☐ Conventional loan or
☐ Connecticut Health and Educational Facilities Authority (CHEFA) financing:

Current CHEFA debt	$ _____
Amount of total debt	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years
Debt service reserve fund	$ _____

☐ Lease financing:

Capital or operating	$ _____
Fair market value of leased assets at lease inception	$ _____
Interest rate	_____ %
Monthly payment	$ _____
Term	_____ Years

☐ Other financing alternatives:

Amount	$
Source (e.g., donated assets, etc.)	

B. Please provide copies of the following, if applicable:
   i. Letter of interest from the lending institution,
   ii. Letter of interest from CHEFA,
   iii. Amortization schedule (if not level amortization), and
   iv. Lease agreement.

11. Revenue, Expense and Volume Projections

A. Payer Mix Projection

Please provide both the current payer mix and the projected payer mix with the CON proposal for the Total Facility based on Net Patient Revenue in the following reporting format:

Total Facility Description	Current Payer Mix	Year 1 Projected Payer Mix	Year 2 Projected Payer Mix	Year 3 Projected Payer Mix
Medicare*				
Medicaid* (includes other medical assistance)				
TriCare (CHAMPUS)				
Total Government Payers				
Commercial Insurers*				
Self-Pay				
Workers Compensation				
Total Non-Government Payers				
Uncompensated Care				
Total Payer Mix	100.0%	100.0%	100.0%	100.0%

*Includes managed care activity.

B. Provide the following for the financial projections:

i) A summary of revenue, expense and volume statistics, with the CON project, without the CON project and incremental to the CON project. **See attached.**

ii) The assumptions utilized in developing the projections (e.g., FTE's, volume statistics, other expenses, revenue and expense % increases, project implementation date, etc.).

iii) An explanation for any projected incremental losses from operations contained in the financial projections that result from the CON proposal.

12. Project Specific Questions

A. Provide a detailed description of the care and services that are currently provided at the Clinic.

B. Discuss how the services described above will continue to be made available to the patients. List any special populations utilizing the services and explain how these clients will continue to access the services should the Clinic be closed.

C. Provide a detailed breakdown of the patients town of origin by zip code type of service provided, i.e. obstetrical vs. gynecological.

D. Identify each practitioner and each office location. Label locations as primary or satellite.

E. Provide information and supporting documentation addressing the issue of transportation for the Clinic's patients. For each area describe how patients would be able to travel to a private physician's office without benefit of a personal vehicle.

F. Describe how the physicians will benefit from the incorporation of the Clinic's patients, specifically addressing the issue of patients that rely on government payments for their care.

G. What effect will the discontinuance of the Clinic have on other services within the Hospital?

H. Provide in your responses copies of any documents or agreements (e.g., transfer) that are being proposed in relation to the Hospital's request to close the Clinic.

11. B(i). Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:	FY	FY	FY	FY	FY	FY	FY	FY	FY
Description	Actual Results	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON	Projected W/out CON	Projected Incremental	Projected With CON
Govt. Gross Revenue	$	$	$	$	$	$	$	$	$	$
Non-Govt. Gross Revenue										
Total Gross Patient Revenue	$	$	$	$	$	$	$	$	$	$
Less: Uncompensated Care	$	$	$	$	$	$	$	$	$	$
Less: Other Deductions										
Total Net Patient Revenue	$	$	$	$	$	$	$	$	$	$
Plus: Other Operating Revenue										
Revenue from Operations	$	$	$	$	$	$	$	$	$	$
Salaries and Fringe Benefits	$	$	$	$	$	$	$	$	$	$
Professional Services										
Supplies and Drugs										
Lease Expense										
Depreciation/Amortization										
Interest Expense										
Other Operating Expense										
Total Operating Expense	$	$	$	$	$	$	$	$	$	$
Gain/(Loss) from Operations	$	$	$	$	$	$	$	$	$	$
Plus: Non-Operating Revenue										
Revenue Over/(Under) Expense	$	$	$	$	$	$	$	$	$	$
Number of Full Time Equivalent Employees:										
*Volume Statistics:										

*Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

HOSPITAL AFFIDAVIT

Applicant: _____

Project Title: _____

I, _____, _____
(Name) (Position – CEO or CFO)

of _____ being duly sworn, depose and state that the (Hospital Name) information submitted in this Certificate of Need application is accurate and correct to the best of my knowledge. With respect to the financial impact related to this CON application, I hereby affirm that:

1. The proposal will have a capital expenditure in excess of $15,000,000.

   ☐ Yes ☐ No

2. The combined total expenses for the proposal's first three years of operation will exceed one percent of the actual operating expenses of the Hospital for the most recently completed fiscal year as filed with the Office of Health Care Access.

   ☐ Yes ☐ No

_____ _____
Signature Date

Subscribed and sworn to before me on_____

_____

Notary Public/Commissioner of Superior Court

My commission expires: _____

OFFICE OF HEALTH CARE ACCESS

REQUEST FOR NEW CERTIFICATE OF NEED

FILING FEE COMPUTATION SCHEDULE

APPLICANT: _____ PROJECT TITLE: _____ DATE: _____	FOR OHCA USE ONLY: DATE INITIAL 1. Check logged (Front desk) _____ _____ 2. Check rec'd (Clerical/Cert.) _____ _____ 3. Check correct (Superv.) _____ _____ 4. Check logged (Clerical/Cert).) _____ _____

SECTION A – NEW CERTIFICATE OF NEED APPLICATION	
1. Check statute reference as applicable to CON application (see statute for detail):	
_____ 19a-638.Additional function or service, Change of Ownership, Service Termination. **No Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000. **Fee Required.**	
_____ 19a-639 Capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000. **Fee Required.**	
_____ 19a-638 and 19a-639. **Fee Required.**	
2. Enter $0 on "Total Fee Due" line (SECTION B) if application is required pursuant to Section 19a-638 only, otherwise go on to line 3 of this section.	
3. Enter $400 on "Total Fee Due" line (SECTION B) if application is for capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $400,000 but less than or equal to $1,000,000	
4. Section 19a-639 fee calculation (applicable if section 19a-639 capital expenditure for major medical equipment, imaging equipment or linear accelerator exceeding $1,000,000 or other capital expenditure exceeding $1,000,000 is checked above **OR** if both 19a-638 and 19a-639 are checked):	
a. Base fee: _____	$ 1,000.00
b. Additional Fee: (Capital Expenditure Assessment)_____ (To calculate: Total requested Capital Expenditure including capitalized financing costs multiplied times .0005 and round to nearest dollar.) ($_____ x .0005)	$_____.00
c. Sum of base fee plus additional fee: (Lines A3a + A3b)_____	$_____.00
d. Enter the amount shown on line A3c. on "Total Fee Due" line (SECTION B).	
SECTION B TOTAL FEE DUE: _____	$_____.00

ATTACH HERE CERTIFIED OR CASHIER'S CHECK ONLY (Payable to: Treasurer, State of Connecticut)

w:\cert\conforms\confeenew